

What is happening in general practice? – Derby KONP, 29 October 2019

What is your experience?

GP Training: 5 years at medical school.

- then 2 years Foundation training in hospital post
- then 3 three years of GP Specialty Training, normally including 18 months in an approved training practice with a further 18 months in approved hospital posts
- (some trainees will work in other specialties in hospital between finishing foundation years and entering GP specialty training)
- minimum of 10 years to train a GP; UK medical school places increasing from 6000 to 7500, but will take a long time for NHSE's '5000 new GPs' – promised by 2021!)

From 2006-13: (Nuffield Trust; <https://www.nuffieldtrust.org.uk/resource/is-general-practice-in-crisis>) -

- GP posts up 4%; consultants in hospital and community up 27%
- Health Education England – 50% of medical students should go into general practice, but actually only 40% do so at present
- 1 in 10 GP training posts unfilled
- 1/3 of GPs under 50 stated leaving clinical care in next 5 years (but 50% of GPs >50)
- Number of single doctor practices halved, number of practices >10 docs up by 76%
- 3.8% (£287m) reduction in spending on GP services

<https://www.rcgp.org.uk/policy/workforce.aspx> -

- 16% increase in GP workload over last 5 years
- by 2025, 9.1m people living with multiple serious long term conditions (55% of GP appointments)
- 10,000 more GPs needed

General Practice is changing

- historically, businesses (independent contractors) - but part of the NHS
- the number of full-time equivalent GP partners has fallen 4 per cent for each of the past three years to March 2019, while the number of Full Time Equivalent salaried GPs has risen by at least 5 per cent in each of the same three years (i.e. less appetite for taking on business aspects of general practice; discussion re salaried service or partnership model)
- NHS Digital: number of FTE GPs down by 576 over past year; headcount increased 2.3% due to trainees (Matt Hancock praised increase in GP numbers across country!)
- 720,000 more patients registered with GPs this year
- half of all GPs taking part in recent survey said they work beyond their rostered hours at least weekly and feel they cannot cope on a weekly basis

- survey also revealed a third of all doctors intend to reduce their hours in clinical practice within the next year, and 10% intend to take a break from practising medicine over the next year
- increasing workload comes from: long term conditions – complex patients; prevention; domestic violence; safeguarding, etc. etc. the “left shift” from hospital to community = more work for GPs
- practices merging; mega-practises; not embedded in community; cant know patients in same way; therapeutic relationship not there (basis of general practice)
- continuity of care in primary care reduces morbidity and mortality; also have role in protecting patients from health care – but not a policy priority. Good for doctors and patients

Workload is considerable:

- 70% people see GP in 1 year, 90% in 5 years. Only 1 in 20 referred on to specialists (important gatekeeping role)
- GP's seeing >1m people a day; average GP seeing twice as many people/day as 30 years ago
- 11 hour days, 41 daily contacts and half GPs working at unsafe levels

Recruitment difficult:

- early retirement; pension issues
- increase in suicide rate: Office for National Statistics showing that 430 health professionals in England and Wales died by suicide from 2011 to 2015, including 81 doctors (= 1 every 18 days), and that female GPs have four times the risk of suicide than the general UK population
- 244 surgeries closed last year; 583 since 2013
- over past year FTE fully qualified GPs fell by 441
- GPs get the blame/stress – e.g. nearly half GPs had patient referral bounced back on 2 week cancer pathway, or downgraded to non-urgent

Primary Care Network:

- the stated aims of PCNs are to tackle the crisis in General Practice, in particular the **crisis in recruitment and retention of GPs**, by deploying a wider range of health care workers to “take the pressure off GPs”; to encourage GP practices to be part of wider multi-disciplinary teams to deliver improved community based care, thus reducing demand on hospitals; and to incentivise GPs to work together to tackle wider health issues, and reducing health inequalities, as outlined in the NHS Long Term Plan.
- £2.3bn going into PCN by 2023 – welcomed by some as way of getting extra resources; others more sceptical (“nail in coffin of tradition general practice?”); most GPs ambivalent
- core primary care contract still there
- but this would change with an Integrated Care Provider contract - covers 1-2 million people, for 10-15 years - GP's give up their own individual

- contract; GPs against ICP contract – say it will undermine benefits of working and collaborating together and improving community services
- is it all part of the big plan, or a bulwark against ICP (promoted by NHS England, whereby GPs would give up their practice contract and patient list and merge into a massive organisation covering hundreds of thousands of people)?
 - most extra funding in the new contract will not go into core GP services but into Primary Care Networks – a total of £1.8 billion a year by 2022
 - to access this funding GP practices in England must sign an extension to their contract to link up with other practices in neighbourhood groups of 30-50,000 patients
 - for signing up to the PCN each practice will be paid £1.76 per patient on their list
 - further payments will be paid directly to the PCN. This will include £1 per patient for all practices in the PCN; funding for clinical pharmacists, and social prescribers in the first year; and funding for a PCN clinical director. In future years there will be funding for physiotherapists, physicians' associates and paramedics.
 - most GPs are not paying attention to 'restricting referrals' incentive – potentially hugely undermining of patient trust
 - GPs should be able to stay in control and develop sensible collaboration to improve services (says BMA)
 - equivalent of 270 GP taken away from front line care in role as PCN directors

Will PCNs rescue General Practice?

- PCN ideas of greater collaboration between practices, multi-disciplinary team working around the patient, especially the most complex and vulnerable, and a wider range of practitioners to provide patient care are not in themselves bad
- wont reduce the need for GPs (7000 short)
- the increased funding to General Practice is **not enough to make up for the loss of £1 billion/year over the last decade**
- it is **unclear where the extra staff will come from** (there is a GP and practice nurse workforce crisis, as well as a wider NHS staffing shortage of 100,000)
- **cuts to public health, preventive services, social care and community services have further undermined the possibilities** of improving care in the community. Add to that the **on-going impact of austerity, poverty and inequality** and it seems unlikely PCNs will have much impact on health inequalities, given that they have no power over those wider issues.
- ***PCNs therefore are not the solution to the GP workforce crisis.***
- **Government policy over the past decade has actively undermined General Practice** and led to the crisis that it currently faces. The future of General Practice is in jeopardy

What to do

- locally - join Patient Participation Group at your GP practice
- nationally - fight for proper funding – increase medical school places – increased GP training places – increased nurse training (N.B. no money for training in Mrs May deal)
- recognise huge impact of austerity and poverty on patients and therefore GPs
- demoralisation of GPs; KONP did not campaign against PCN – but did campaign for what we want for primary care (see below)
- General Practice should be an attractive job; 10 minutes/patient, complexity and risk – lets have 20 minutes appointments, breaks, educational sessions – look after the staff – time for the patient, and nurturing the people – needs injection of funding (see also: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/building-the-workforce-new-deal-gp.pdf>)
- The Charter for General Practice – campaigning around positive demands:

KONP Primary Care Charter (DRAFT)

GP services in the NHS: our demands

SUPPORT THE CURRENT GP MODEL THAT GIVES CONTINUITY OF CARE

- Support the traditional model of General Practice that enables personal and continuing care.
- FULLY FUND IT: Significantly increase core funding to General Practice
- NHSE must end its selective promotion of “GP at Scale” and practice mergers and increase its support to small and medium sized practices, to ensure their flourishing and survival.
- NHSE must consult patients and public about any plans to merge or close practices, including the creation of “super practices”, and provide impact assessments of such plans on travelling time and distances, availability of GP appointments, and continuity of care.

OPPOSE PRIVATISATION AND CORPORATISATION OF GENERAL PRACTICE

- We oppose the takeover of general practice and primary care by for-profit corporations, including digital providers such as Babylon.
- We oppose plans for Integrated Care Providers, and other corporate models of primary care provision.
- We note the risks inherent in Primary Care Networks (PCNs) and oppose any moves to privatise Primary Care Networks or incorporate them into private provider organisations such as Accountable Care Organisations.

- All staff employed by PCNs should be employed on NHS terms and conditions and pensions.

RIGHT TO SEE YOUR GP

- We demand 10,000 more GPs as recommended by the Royal College of General Practitioners, to improve access and waiting times to see a GP, and to facilitate continuity of care with a known GP.
- We demand the right for patients to have face to face appointments with a GP if that is what they prefer.
- We demand an end to the use of IT and APPs as barriers to accessing GPs. All IT must serve to enhance and support General Practice, not replace it.

MULTI-DISCIPLINARY TEAMS ADDITIONAL TO, NOT REPLACING GPs

- Increase the training and funding for practice nurses.
- Increase training and funding for other clinical staff to work in practices such as clinical pharmacists and counsellors. Such additional staff to be complementary to and not replacements for GPs.
- Increase numbers of community staff such as district nurses, health visitors, school nurses, community diabetic and respiratory nurse specialists, community palliative care nurses and community mental health staff.
- Fund adequate wider services to support primary care in the community including social care, public health and mental health services. This will require a reversal of cuts to local authority budgets, and increased budgets to make up for years of underfunding.

PATIENT & PUBLIC ACCOUNTABILITY AND ENGAGEMENT IN PRIMARY/COMMUNITY CARE

- Opportunities for genuine patient and public involvement in the development of health services including primary care.
- No merger of CCGs. Retention of the right of CCGs to veto Integrated Care System plans if they consider they are wrong for the area the CCG covers.
- Enhanced rights for local government scrutiny committees to interrogate, challenge and veto decisions of the ICS which go against the interests of local communities.

EQUALITY OF ACCESS FOR ALL

- Remove barriers for marginalised groups in accessing GP care
- Oppose any moves to start charging migrants and others for GP care
- Provide support to homeless people, migrants and other disadvantaged groups to register with a GP practice

- Fully fund interpreting services for GP practices

NHS RATIONING AND BARRIERS TO SPECIALIST CARE

- End referral management systems that act as barriers to GPs referring for further care
- End restrictions on GPs' freedom to refer.
- Allow GPs to prescribe medications that can be bought over the counter
- End prescription charges
- Abolish the current list of banned procedures on the NHS. All procedures for which NICE provides evidence of benefit should be available on NHS.